Gastroenterology Prescription Referral Form

Carepoint Pharmacy
Phone: 732-885-1000 **Fax: 732-980-0357**
10 Plainfield Ave., Suite 1, Piscataway, New Jersey 08854 www.carepointpharmacynj.com

Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart			
First Name :	*Middle Initial :*	*Last Name :*	
Date of Birth :	*Gender:* ◯ M ◯ F	*SSN :*	
Street Address :	*City :*	*State :*	*Zip Code :*
Home Phone :	*Work Phone :*	*Cell Phone :*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card			
Insurance Carrier Name - Primary :	*Name of Insured :*		*Relationship :*
ID# :	*Group # :*		*Insurance Phone :*
Rx Carrier Name - Secondary :	*Rx ID# :*	*Rx Group #:*	*Rx Phone # :*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription

Drug Name	Form/Strength/Directions for Use	Qty	Refills
Daklinza	☐ 30mg ☐ 60mg _____ mg once daily in combination with Sovaldi (Sofosbuvir) 400mg once daily.		
Harvoni	☐ 1 tab (90 Mg Ledipasvir & 400mg Sofosbuvir) PO daily		
Olysio	☐ 150mg PO daily		
Ribapak	☐ 200mg PO am & 400mg PO pm ☐ 400mg PO am & 400mg PO pm ☐ 600mg PO am & 400 mg PO pm ☐ 600mg PO am &600 mg PO pm Other _____		
Sovaldi	☐ 400mg PO daily		
Technivie	☐ 2 tablets (12.5mg Ombitasvir, 75mg Paritaprevir, 50mg Ritonavir) po once daily in the morning		
Viekira Pak	☐ Viekira Pak Ombitasvir 12.5 mg - 2 tablets daily PO in am, Paritaprevir 75mg - 2 tablets daily PO in am , Ritonavir 50mg - 2 tablets daily PO in am, Dasabuvir 250 mg PO BID		
Promacta	☐ _____ Mg PO daily		
Cimzia (200mg vials or PFS	☐ lyophilized via ☐ Pre - filled syringe ☐ Initial dosing : 400mg SC at 0, 2, 4 weeks then ☐ Ongoing t reatment: 400 mg SC every 4 weeks		
Humira (supplied as 40mg pens or PFS)	☐ Initial dosing: Crohn's /Ulcerative Colitis Starter Pack - six 40mg single dose pens 160mg (four 40mg injections) SC x one (day 0) then 80mg SC x one two weeks later (day 15) ☐ Ongoing treatment: ☐ Pen or ☐ PFS 40mg SC every other week (Start 29 days after initial dosing Other		
Humira Pediatric (supplied as PFS)	**Initial dosing for children >/= 6 and >/= 40kg :** ☐ 4x40mg inj SC on Day 1 then 2x40mg inj SC 2 weeks later on Day 15 (tray of 6) ☐ 2x40mg inj SC on Days 1 & 2 then 2x40mg inj SC 2 weeks later on Day 15 (tray of 6) **Initial dosing for children >/= 6 and weighing 17kg to < 40kg :** ☐ 2x40mg inj SC on Day 1 then 1x40mg SC 2 weeks later on Day 15 (tray of 3) **Maintenance :** ☐ 40mg SC every other week ☐ 20mg SC every other week		
Simponi	☐ Initial Dosing: 200mg SC week 0 then 100mg SC week 2 ☐ Other _____ ☐ Ongoing treatment: 100mg SC every 4 week ☐ Other _____		
	☐ Other Medication _____		

Primary Diagnosis: _____ *ICD - 10 :* _____ *Genotype:* _____ *Viral load* _____

Weight :	*Height :*	*Allergies :*
Failed Therapies :		Please provide current list of medications :

Complete Prescriber Information in Section Below NOT Included on Attached Prescription

MD First Name :	*MD Last Name :*		*DEA # :*	
UPIN :	*State License # :*	*NPI :*	*Office E-mail :*	
Office Address :		*City :*	*State :*	*Zip Code :*
Office Phone:		*Office Fax :*	*Office Contact Name :*	

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Carepoint Pharmacy to initiate a Prior Authorization on my behalf.*	**Date :**
Dr : Substitution Permitted	**Dr :** No Substitution Permitted